- ❑ Initiate Waiver services
- ❑ Service Modification
  - □ Add a service
  - □ Increase units/hours of service
  - □ Decrease units/hours of service
  - □ Procedure code modification (requires 2 ISAR's)
- ❑ Provider modification (requires 2 ISARs)
- ❑ End a service

DAY SUPPORT WAIVER

Prevocational Services
Individual Service Authorization Request

CSB _____

CSB provider # _____

Do NOT Use for MR Waiver

Provider Name _____ Provider No. _____

Name: _____ (Last, First MI) Start: _____ (Date) End: _____ (Date)

Medicaid Number: _____

CHECK SERVICE TO BE PROVIDED ONLY		WEEKLY / MONTHLY UNITS			OMR USE
☐ H2025 Prevocational, Reg Int. Center Based ☐ H2025 U1 Prevocational, High Int. Center Based ☐ H2025 Prevocational, Reg Int. Non Center Based ☐ H2025 U1 Prevocational, High Int. Non Center Based		_____ Units / week	x 4.6 =	_____ Monthly Total 1	
				+	
Enter **Periodic Support** units per month if needed – **Do not include in hours per day below.**	→			_____ Monthly Total	
				=	
Enter **TOTAL** of periodic support units + regular units per month.	→			_____ Monthly Total 2	

Reason for this request: _____

If High Intensity, check which criteria are met:

☐ Requires physical assistance to meet basic personal care needs

☐ Has extensive disability-related difficulties and requires additional, ongoing support to fully participate in programming and to accomplish individual service goals

☐ Requires extensive personal care and/or constant supports to reduce or eliminate behaviors which preclude full participation in programming. [A formal written behavioral objective is required to address behaviors such as self-injury or self-stimulation.]

Check the allowable activities that are included in the ISP:

Training & support

☐ in skills aimed at preparation for paid employment offered in a variety of community settings

☐ in activities primarily directed at habilitative goals (e.g., attention span and motor skills)

☐ that is focused on completing assignments, solving problems or safety

Assistance & supervision

☐ with personal care

☐ to ensure the individual's health and safety

☐ travel between activity and training sites

There is documentation in the record that Prevocational Services cannot be obtained from the school system (for those less than 22 years) nor from Department of Rehabilitative Services? ☐ **Yes** ☐ **No**

Record the number of hours per day of the following: *(for biweekly/varied schedules, draw a line to indicate different weeks)*	**SUN**	**MON**	**TUES**	**WED**	**THU**	**FRI**	**SAT**
Total Hours of Program Time *(e.g., if individual is in program from 8 a.m. until noon, enter "4")*							
Travel with the individual to & from program: *[record if billing for this time; can be included up to 25% of the total time; to bill for a 3-unit day, a minimum of 7 hrs of other allowable activities is required; does not include training related travel in scheduled activities]*							

ATTACH ADDITIONAL PAGES IF FURTHER EXPLANATION IS NEEDED.

Name of Provider Agency Representative (print) Signature Date

I agree that the above plan of services is appropriate to the identified needs of this individual. This service modification has been approved by the individual and included in the CSP maintained in the Case Manager's record.

CSB Rep/Case Manager (print) Signature Phone No. Fax No. Date